UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

MICHELLE R. GREEN	:	Civil No. 1:17CV01185 (HBF)
v.	:	
NANCY A. BERRYHILL, ACTING COMMISSIONER, SOCIAL SECURITY ADMINISTRATION	:	

RULING ON CROSS MOTIONS

Plaintiff Michelle R. Green brings this action pursuant to 42 U.S.C. §405(g), seeking review of a final decision of the Commissioner of Social Security which denied her application for Disability Insurance Benefits ("DIB") under Title II Social Security, 42 U.S.C. §401 et seq. ("the Act"). Plaintiff has moved to reverse or remand the case for a rehearing. The Commissioner has moved to affirm.

For the reasons set forth below, plaintiff's Motion for Judgment on the Pleadings **[Doc. #15]** is **GRANTED**. Defendant's Motion for Judgment on the Pleadings **[Doc. #22]** is **DENIED**.

I. ADMINISTRATIVE PROCEEDINGS

The procedural history of this case is not disputed. Plaintiff protectively filed an application for DIB on June 11, 2013, alleging disability as of January 23, 2013.[1] [Certified

[1] Plaintiff's date last insured for Title II benefits is March

Transcript of the Record, Compiled on February 3, 2018, Doc. #5 (hereinafter "Tr.") 63, 125-26]. Plaintiff alleged disability due to "spinal cord injury cervical, hern[iated] disc cervical with myelopathy, stenosis cervical, headaches, muscle spasms." [Tr. 64]. Her DIB claim was denied on March 7, 2014. [Tr. 22, 69-72]. Plaintiff filed a timely request for a hearing before an Administrative Law Judge ("ALJ") on March 23, 2014. [Tr. 84-86].

On March 29, 2016, Administrative Law Judge ("ALJ") Carl E. Stephan held a hearing, at which plaintiff appeared with a paralegal and testified. [Tr. 38-62]. No Vocational Expert testified at the hearing. [Tr. 38]. On June 10, 2016, the ALJ found that plaintiff was not disabled, and denied her claim. [Tr. 19-37]. Plaintiff filed a timely request for review of the hearing decision on July 19, 2016. [Tr. 123-24]. On September 14, 2017, the Appeals Council denied review, thereby rendering ALJ Smith's decision the final decision of the Commissioner. [Tr. 1-6]. The case is now ripe for review under 42 U.S.C. §405(g).

Plaintiff, represented by counsel, timely filed this action for review and moves to reverse and/or remand the Commissioner's decision.

31, 2019. [Tr. 24].

II. STANDARD OF REVIEW

The review of a social security disability determination involves two levels of inquiry. First, the Court must decide whether the Commissioner applied the correct legal principles in making the determination. Second, the Court must decide whether the determination is supported by substantial evidence. Balsamo v. Chater, 142 F.3d 75, 79 (2d Cir. 1998) (citation omitted). Substantial evidence is evidence that a reasonable mind would accept as adequate to support a conclusion; it is more than a "mere scintilla." Richardson v. Perales, 402 U.S. 389, 401 (1971) (quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938)). The reviewing court's responsibility is to ensure that a claim has been fairly evaluated by the ALJ. Grey v. Heckler, 721 F.2d 41, 46 (2d Cir. 1983) (citation omitted).

The Court does not reach the second stage of review – evaluating whether substantial evidence supports the ALJ's conclusion – if the Court determines that the ALJ failed to apply the law correctly. See Norman v. Astrue, 912 F. Supp. 2d 33, 70 (S.D.N.Y. 2012) ("The Court first reviews the Commissioner's decision for compliance with the correct legal standards; only then does it determine whether the Commissioner's conclusions were supported by substantial evidence."). "Where there is a reasonable basis for doubt whether the ALJ applied correct legal principles, application of

the substantial evidence standard to uphold a finding of no disability creates an unacceptable risk that a claimant will be deprived of the right to have her disability determination made according to the correct legal principles." Johnson v. Bowen, 817 F.2d 983, 986 (2d Cir. 1987).

"[T]he crucial factors in any determination must be set forth with sufficient specificity to enable [a reviewing court] to decide whether the determination is supported by substantial evidence." Ferraris v. Heckler, 728 F.2d 582, 587 (2d Cir. 1984) (alteration added) (citation omitted). The ALJ is free to accept or reject the testimony of any witness, but a "finding that the witness is not credible must nevertheless be set forth with sufficient specificity to permit intelligible plenary review of the record." Williams ex rel. Williams v. Bowen, 859 F.2d 255, 260-61 (2d Cir. 1988) (citation omitted). "Moreover, when a finding is potentially dispositive on the issue of disability, there must be enough discussion to enable a reviewing court to determine whether substantial evidence exists to support that finding." Johnston v. Colvin, Civil Action No. 3:13-CV-00073(JCH), 2014 WL 1304715, at *6 (D. Conn. Mar. 31, 2014) (internal citations omitted).

It is important to note that in reviewing the ALJ's decision, this Court's role is not to start from scratch. "In reviewing a final decision of the SSA, this Court is limited to

determining whether the SSA's conclusions were supported by substantial evidence in the record and were based on a correct legal standard." Talavera v. Astrue, 697 F.3d 145, 151 (2d Cir. 2012) (citations and internal quotation marks omitted). "[W]hether there is substantial evidence supporting the appellant's view is not the question here; rather, we must decide whether substantial evidence supports the ALJ's decision." Bonet ex rel. T.B. v. Colvin, 523 F. App'x 58, 59 (2d Cir. 2013)(citations omitted).

III. SSA LEGAL STANDARD

Under the Social Security Act, every individual who is under a disability is entitled to disability insurance benefits.

To be considered disabled under the Act and therefore entitled to benefits, Ms. Green must demonstrate that she is unable to work after a date specified "by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. §423(d)(1)(A). Such impairment or impairments must be "of such severity that [s]he is not only unable to do h[er] previous work but cannot, considering h[er] age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy." 42 U.S.C. §423(d)(2)(A); see also 20 C.F.R. §404.1520(c)

(requiring that the impairment "significantly limit[ ] ... physical or mental ability to do basic work activities" to be considered "severe").[2]

There is a familiar five-step analysis used to determine if a person is disabled. See 20 C.F.R. §404.1520(a)(4). In the Second Circuit, the test is described as follows:

> First, the Secretary considers whether the claimant is currently engaged in substantial gainful activity. If he is not, the Secretary next considers whether the claimant has a "severe impairment" which significantly limits his physical or mental ability to do basic work activities. If the claimant suffers such an impairment, the third inquiry is whether, based solely on medical evidence, the claimant has an impairment which is listed in Appendix 1 of the regulations. If the claimant has such an impairment, the Secretary will consider him disabled without considering vocational factors such as age, education, and work experience; the Secretary presumes that a claimant who is afflicted with a "listed" impairment is unable to perform substantial gainful activity.

Berry v. Schweiker, 675 F.2d 464, 467 (2d Cir. 1982) (per curiam). If and only if the claimant does not have a listed impairment, the Commissioner engages in the fourth and fifth steps:

> Assuming the claimant does not have a listed impairment, the fourth inquiry is whether, despite the claimant's severe impairment, he has the residual functional capacity to perform his past work. Finally, if the claimant is unable to perform his past work, the Secretary then determines whether there is other work

[2] DIB and SSI regulations cited herein are virtually identical. The parallel SSI regulations are found at 20 C.F.R. §416.901 et seq., corresponding to the last two digits of the DIB cites (e.g., 20 C.F.R. §404.1520 corresponds with 20 C.F.R. §416.920).

> which the claimant could perform. Under the cases previously discussed, the claimant bears the burden of proof as to the first four steps, while the Secretary must prove the final one.

Id.

"Through the fourth step, the claimant carries the burdens of production and persuasion, but if the analysis proceeds to the fifth step, there is a limited shift in the burden of proof and the Commissioner is obligated to demonstrate that jobs exist in the national or local economies that the claimant can perform given his residual functional capacity." Gonzalez ex rel. Guzman v. Dep't of Health and Human Serv., 360 F. App'x 240, 243 (2d Cir. 2010) (citing 68 Fed. Reg. 51155 (Aug. 26, 2003)); Poupore v. Astrue, 566 F.3d 303, 306 (2d Cir. 2009) (per curiam)). "Residual functional capacity" is what a person is still capable of doing despite limitations resulting from her physical and mental impairments. See 20 C.F.R. §§404.1545(a), 416.945(a)(1).

"In assessing disability, factors to be considered are (1) the objective medical facts; (2) diagnoses or medical opinions based on such facts; (3) subjective evidence of pain or disability testified to by the claimant or others; and (4) the claimant's educational background, age, and work experience." Bastien v. Califano, 572 F.2d 908, 912 (2d Cir. 1978) (citation omitted). "[E]ligibility for benefits is to be determined in light of the fact that the Social Security Act is a remedial

statute to be broadly construed and liberally applied." Id. (citation and internal quotation marks omitted).

IV. THE ALJ'S DECISION

Following the above-described five step evaluation process, ALJ Stephan concluded that plaintiff was not disabled under the Social Security Act. [Tr. 19-37]. At step one, the ALJ found that plaintiff had not engaged in substantial gainful activity since January 23, 2013, the alleged onset date. [Tr. 24].

At step two, the ALJ found that plaintiff had cervical sprain and strain; cervical spondylosis; cervical disc herniation without myelopathy; and lumbar strain, all of which are severe impairments under the Act and regulations. [Tr. 24-28]

At step three, the ALJ found that plaintiff's impairments, either alone or in combination, did not meet or medically equal the severity of one of the listed impairments in 20 C.F.R. Pt. 404, Subpart P, Appendix 1. [Tr. 28]. The ALJ specifically considered Listing 1.04 (disorders of the spine). [Tr. 28]. The ALJ also conducted a psychiatric review technique and found that plaintiff had a no restriction in activities of daily living or social functioning, and a mild restriction in concentration, persistence or pace. [Tr. 26-27]. The ALJ found no episodes of decompensation. [Tr. 27].

Before moving on to step four, the ALJ found plaintiff had

the RFC "to perform the full range of light work, as defined in 20 C.F.R. 404.1567(b)." [Tr. 28].

At step four, the ALJ found plaintiff was unable to perform any past relevant work. [Tr. 31]. At step five, after considering plaintiff's age, education, work experience and RFC, the ALJ found that jobs existed in significant numbers in the national economy that plaintiff could perform. [Tr. 31-32].

The ALJ concluded that plaintiff had not been under a disability from January 23, 2013, the alleged onset date of disability, through June 10, 2016, the date of the ALJ's decision. [Tr. 32].

V. DISCUSSION

Plaintiff first argues that the "Commissioner erred in substituting her own 'medical' judgment for that of any physician." [Doc. #15-1 at 21-26]. She contends that "the ALJ erred by rejecting all treating provider opinions, granting 'considerable' weight to the vague opinion of the insurance company consultant Dr. Medved, and then effectively formulating a function-by-function physical RFC without any medial authority." [Doc. #15-1 at 23-26]. She next argues that the ALJ erred at Step Three in failing to consider Ms. Green's lumbar spine injury under Medical Listing 1.04(A) after the second motor vehicle accident. [Doc. #15-1 at 26-32]. Finally,

plaintiff contends that the ALJ erred in ignoring and failing to evaluate or weigh the opinion of treating orthopedic surgeon Dr. Cameron Huckell. [Doc. #15-1 at 32-36].

An ALJ has the responsibility to determine a claimant's RFC based on all the evidence of record. 20 C.F.R. §§404.1545(a)(1), 416.945(a)(1). The RFC is an assessment of "the most [the disability claimant] can still do despite [his or her] limitations." 20 C.F.R. §404.1545(a)(1), 416.945(a)(1). Although "[t]he RFC determination is reserved for the commissioner...an ALJ's RFC assessment is a medical determination that must be based on probative evidence of record.... Accordingly, an ALJ may not substitute his own judgment for competent medical opinion." Walker v. Astrue, No. 08-CV-0828(A)(M), 2010 WL 2629832, at *6 (W.D.N.Y. June 11, 2010)(quoting Lewis v. Comm'r of Soc. Sec., No. 6:00CV1225(GLS), 2005 WL 1899, at *3 (N.D.N.Y. Aug. 2, 2005)(internal citations omitted)). Nevertheless, plaintiff has the burden to demonstrate functional limitations that would preclude any substantial gainful activity. See 20 C.F.R. §§§404.1545(a)(3), 416.945(a)(3) ("In general, you are responsible for providing the evidence we will use to make a finding about your residual functional capacity."); 42 U.S.C. §423(d)(5)(A)("An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence

of the existence thereof as the Commissioner of Social Security may require.").

Pursuant to 20 C.F.R. §§404.1527(c)(2) and 416.927(c)(2), a treating source's opinion will usually be given more weight than a non-treating source. If it is determined that a treating source's opinion on the nature and severity of a plaintiff's impairment is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] case record," the opinion is given controlling weight. 20 C.F.R. §§404.1527(c)(2), 416.927(c)(2). If the opinion, however, is not "well-supported" by "medically acceptable" clinical and laboratory diagnostic techniques, then the opinion cannot be entitled to controlling weight. Id. If the treating source's opinion is not given controlling weight, the ALJ considers the following factors in weighing the opinion: length of treatment relationship, frequency of examination, nature and extent of the treatment relationship, relevant evidence used to support the opinion, consistency of the opinion with the entire record, and the expertise and specialized knowledge of the source. See 20 C.F.R. §§404.1527(c)(2)-(6), 416.927(c)(2)-(6); Social Security Ruling ("SSR") 96-2P, 1996 WL 374188, at *2 (S.S.A. July 2, 1996). "While an ALJ may discount a treating physician's opinion if it does not meet this standard, the ALJ must 'comprehensively set

forth [his] reasons for the weight assigned to a treating physician's opinion.'" Pilarski v. Comm'r of Soc. Sec., No. 13-CV-6385-FPG, 2014 WL 4923994, at *2 (W.D.N.Y. Sept. 30, 2014)(quoting Halloran v. Barnhart, 362 F.3d 28, 33 (2d Cir. 2004).

Here, the ALJ found that plaintiff had the RFC to "perform the full range of light work, as defined in 20 C.F.R. §404.1567." [Tr. 28]. The regulations dictate the physical exertion requirements of light work:

> Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

20 C.F.R. §404.1567.

The administrative record in this case contains numerous detailed treatment records, and medical opinions from treating and other examining sources that relate the medical evidence to what plaintiff can and cannot do functionally. Plaintiff accurately points out that there are numerous disability assessments, supported by functional limitation, by her treating

providers in the record and there is no dispute that plaintiff was disabled from returning to her work as a CNA. [Tr. 31]. It is also undisputed that plaintiff did not work after the first motor vehicle accident on January 23, 2013, that the injuries sustained were due to the accident, and that conservative treatment did not relieve her symptoms. After a second motor vehicle accident on February 20, 2014, it is also undisputed that plaintiff sustained injuries to her lumbar spine and this accident was an aggravating/activating event to a pre-existing cervical condition.

Notably, the ALJ did not assess the opinion of treating orthopedic surgeon Dr. Cameron Huckell in making his RFC determination, as conceded by defendant. [Doc. #22-1 at 19]. Defendant argues that "[a]lthough the ALJ did not explicitly mention [the October 2014 disability statement], the ALJ's decision was consistent with Dr. Huckell's statement" and the RFC assessment "was based on all the relevant medical evidence and other evidence of record, including Plaintiff's own statements." [Doc. #22-1 at 19-20 (emphasis added)]. The Court disagrees. The failure to evaluate an opinion by a treating physician, however brief, requires remand. Schramm v. Colvin, No. 13-CV-806S, 2014 WL 4627222, at *3 (W.D.N.Y. Sept. 15, 2014)("[T]he Appeals Council, like the ALJ, is required to provide "good reasons" for rejecting treating-source opinions—

even laconic opinions."); 20 C.F.R. § 416.927(c)(2) ("We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.")(emphasis added). The ALJ was free to reject or discount Dr. Huckell's opinion, but in making that decision, the ALJ had to address the opinion and offer his rationale for doing so. Schramm, 2014 WL 4627222, at *4 ("On remand, the Commissioner must offer 'good reasons' for rejecting Dr. Ambis' opinion, or request more information from Dr. Ambis.").

During the relevant period under review, there is no opinion of record by a treating physician or other medical provider that plaintiff was able to work and/or was ready to return to work. Rather, the ALJ's decision in large part indicates that he impermissibly assessed plaintiff's RFC on the basis of bare medical findings, and substituted his own judgment for competent medical opinion.

This is not a case where plaintiff suffers relatively little physical impairment, such that the ALJ may render a common sense judgment about plaintiff's functional capacity. The ALJ acknowledged as much by designating plaintiff's cervical sprain and strain; cervical spondylosis; cervical disc herniation without myelopathy; and lumbar strain "severe." [Tr. 24-28].

Moreover, throughout the treating relationship with Dr.

Huckell, the doctor opined that plaintiff was temporarily totally disabled as a result of the motor vehicle accident in January 2013 and was unable to return to her job. [Tr. 244 (8/8/13), Tr. 234 (10/9/13), Tr. 228 (12/5/13), Tr. 222 (12/17/13). By March 2014, and after the second motor vehicle accident in February 2014, Dr. Huckell opined that he considered plaintiff to have a permanent partial disability. [Tr. 388 (3/21/14), Tr. 401 (6/18/14), Tr. 414 (8/7/14), Tr. 450 (10/4/14)].

Dr. Huckell's treatment notes include detailed notations of physical examination of plaintiff's musckuloskeletal system (including gait, physical inspection, range of motion, strength, straight leg raises), neurologic system (including deep tendon reflexes, sensation and pathologic reflexes), and her psychiatric status. [Tr. 218, 233, 243, 384, 394-95, 405-06, 442-43]. Beginning in December 2013, Dr. Huckell noted that conservative care, including chiropractic, massage and physical therapy, did not improve her symptoms. [Tr. 217, 226]. On examination, Dr. Huckell noted that plaintiff's "left grip strength is 25% less than a right grip strength indicating that the spinal cord compression and nerve root compression left side is starting to cause some neurological problems that are objective." [Tr. 217, 226]. At that time, plaintiff provided a consent to surgery. [Tr. 221]. The doctor stated,

> Michelle is now developing some early signs of myelopathy and there is an indication for surgery. I explained to her that she is a candidate for anterior cervical discectomy and fusion and allograft bone cage and plate C5-7. There is no indication for further physical therapy since she has had neurological worsening.
>
> Review of the thoracic spine MRIs dated 4/12/13 shows pathology consisting of multilevel disc bulging with mild upper thoracic spondylosis. As there is no significant central stenosis at any level, there is no immediate indication for surgery to her thoracic spine and we are not recommending it at this time.
>
> Because of the worsening neurological condition I consider [her to] be temporarily totally disabled for all work. We are planning on proceeding with surgery relatively soon. Michelle will remain out of work.

[Tr. 222, 228]. In March and June 2014, Dr. Huckell noted that "[w]e are planning on proceeding with surgery relatively soon." [Tr. 388, 401], However, despite providing consent to surgery, Dr. Huckell noted in August and October 2014, that plaintiff "is not ready to commit [to] any surgical intervention yet which is reasonable." [Tr. 404, 441].

After the second MVA in February 2014, Dr. Huckell stated

> Causality: It is my opinion that Michelle sustained significant injuries to her lumbar spine and an aggravating/activating event to pre-existing symptomatic cervical spinal condition as a result of this motor vehicle accident. Michelle settled with her first MVA case (01/23/13)
>
> Disability: It is my opinion that Michelle is considered to have a permanent partial disability at this time as a result of the first motor vehicle accident dated 1/23/13. A FCE [functional capacity

> evaluation] can be done for specific limitations/restrictions if warranted. She was not working at the time of her second MVA (02/20/2014). Therefore, no disability status is needed/warranted at this time regarding the second MVA.

[Tr. 388-89 (3/21/14), 401 (6/18/14), 414 (8/17/14)]. A functional capacity evaluation was not performed or, if done, is not part of the record.

In the last treatment record in October 2014, on physical examination Dr. Huckell noted paravertebral muscle rigidity. Cervical range of motion revealed, flexion 45 degrees/0-60 degrees, extension 40 degrees/0-75 degrees, bending to right 15 degrees/0-45 degrees, rotation to right 65 degrees/0-80 degrees, rotation to left 50 degrees/0-80 degrees. Thoracic range of motion revealed flexion 40 degrees/0-50 degrees, rotation 15 degrees/10-30 degrees, rotation to left 15 degrees/10-30 degrees. Lumbar range of motion revealed flexion 40 degrees/0-60 degrees, extension 10 degrees/0-25 degrees, bending to right 20 degrees/0-25 degrees, bending to left 20 degrees/0-25 degrees. The doctor noted functional range of motion of shoulders, elbows, wrists, hips, knees, and ankles. Strength was 5/5 bilaterally for the upper extremities including intrinsic muscles of hands. Grip strength was firm bilaterally. However, in objective grip strength testing, the doctor noted that plaintiff's right hand achieved a crit of 28 kg of force and her left hand was 25% less than 22 kg of force, "which is clearly

objective evidence of weakness in a left-handed individual." [Tr. 443]. Straight leg raises were positive on the left side at approximately 50 degrees. Deep tendon reflexes 2+ at the bilateral knees and ankles, 3+ at the bilateral upper extremities and plaintiff has spreading to other muscle groups at proximal joints. Sensation was intact to light touch bilaterally to upper and lower extremities. Finally, pathologic reflexes showed Hoffman sign were bilaterally positive. [Tr. 443].

On October 7, 2014, Dr. Huckell added, that while "[s]he was not working at the time of her second MVA (02/23/2014) the second accident activated/aggravated her pre-existing condition and continued her loss of work to some extent." [Tr. 450]. The doctor "recommended against lumbar surgery for her condition although she might be helped by lumbar epidural steroids." [Tr. 441; see Tr. 452 (Dr. Huckell referred her to Dr. Waghmarae for consideration of epidural steroids and possibility of pain management).

Dr. Huckell provided the following disability opinion on October 7, 2014,

> Michelle Green is disabled for work at this time and will remain so for a period of at least 3 months from today in my opinion. She has also been disabled from work between January 21, 2013 and February 20, 2014 as a result of the first car accident January 21, 2013. Her condition was worsened by the second car accident dated February 20, 2014 this prolong[s] her period of

> inability to work. She formerly worked at a nursing home in Orchard Park as a certified nursing assistant. Both of these car accidents rendered her totally disabled for that type of work.

[Tr. 453].

Instead of addressing Dr. Huckell's opinion, the ALJ ignored it, writing that

> David H. Joslyn, a registered physician's assistant in Dr. Huckell's office reported in April 2014 (Exhibit 11F) and September 2014 (Exhibit 13F) that the claimant is totally disabled. The Administrative Law Judge finds little support for his statements, since reports from Dr. Huckell the claimant's treating orthopedist, indicate that the claimant's disability is of a temporary nature (Ex. 2F and 3F).

[Tr. 30]. Plaintiff correctly states that "the ALJ did not address Dr. Huckell's opinion, as he assumed the reports from Pinnacle indicating that Ms. Green is totally disabled came from the physician assistant Mr. Joslyn (Tr. 30) and thus are not governed by 20 C.F.R. §404.1527." [Doc. #15-1 at 34]. As set forth above, Dr. Huckell examined plaintiff, reviewed the diagnostic imaging and co-signed these reports.

The Commissioner argues that since the ALJ found that plaintiff could perform light or sedentary work, that this is consistent with Dr. Huckell's October 7, 2014 opinion precluding her work as a certified nurse assistant. [Doc. #22-1 at 19-20]. However, Dr. Huckell did not specifically state why Ms. Green could not perform her past work. The doctor documented "objective" evidence of weakness to plaintiff's dominant left

hand and arm, left upper and lower extremities with neurological worsening throughout the treatment history. [Tr. 217, 222, 226-27, 383, 388, 393, 400-01, 404, 406, 441, 443, 450]. However, the ALJ's RFC determination makes no mention of additional functional limitations due to plaintiff's dominant left hand/arm radicular symptoms. Nor did the ALJ include any manipulative or postural limitations to account for these radicular symptoms to plaintiff's left dominant hand or other neurological worsening to her left upper and lower extremities.

"Because the ALJ failed to cite to any medical opinion to support his RFC findings, the Court is unable to determine if the ALJ improperly selected separate findings from different sources, without relying on any specific medical opinion." Hogan v. Astrue, 491 F. Supp. 2d 347, 354 (W.D.N.Y. 2007).

> Where, as here, the medical findings and reports merely diagnose the claimant's impairments without relating the diagnoses to specific physical, mental, and other work-related capacities, the administrative law judge's "determination of residual functional capacity without a medical advisor's assessment of those capacities is not supported by substantial evidence." Given Plaintiff's multiple physical and mental impairments, this is not a case where the medical evidence shows "relatively little physical impairment" such that the ALJ "can render a common sense judgment about functional capacity."

Palascak v. Colvin, No. 1:11-CV-0592 MAT, 2014 WL 1920510, at *9 (W.D.N.Y. May 14, 2014): see also House v. Astrue, No. 5:11-CV-915 GLS, 2013 WL 422058, at *4 (N.D.N.Y. Feb. 1,

2013)("[A]lthough the RFC determination is an issue reserved for the commissioner, an ALJ is not qualified to assess a claimant's RFC on the basis of bare medical findings and as a result, an ALJ's determination of RFC without a medical advisor's assessment is not supported by substantial evidence.")(internal citation and quotation marks omitted).

Because the ALJ failed to assess Dr. Huckell's opinion and dismissed the opinions from other treating medical sources there is no medical opinion regarding Green's functional capacity to complete the activities for a full range of light work or sedentary work. Martin v. Berryhill, No. 16-CV-6184-FPG, 2017 WL 1313837, at *3 (W.D.N.Y. Apr. 10, 2017)("Because the ALJ rejected Dr. Finkbeiner's opinion, the record lacks any medical opinion as to Martin's physical ability to engage in work at any exertional level on a regular and continuous basis in an ordinary work setting. There is no medical opinion regarding her capacity to sit, stand, walk, or lift, which are necessary activities for sedentary work. See 20 C.F.R. §§ 404.1567(a), 416.967(a)."). The ALJ's failure to evaluate the opinion of treating orthopedic surgeon Dr. Huckell is error requiring remand.

While the Commissioner is free to decide that the opinions of acceptable medical sources and other sources are entitled to no weight or little weight, those decisions should be thoroughly

explained. Sears v. Astrue, Civil Action No. 2:11-CV-138, 2012 WL 1758843, at *3 (D. Vt. May 15, 2012). Indeed, when an ALJ rejects all physician opinion evidence, an evidentiary deficit exists. "[E]ven though the Commissioner is empowered to make the RFC determination, '[w]here the medical findings in the record merely diagnose [the] claimant's exertional impairments and do not relate those diagnoses to specific residual functional capabilities,' the general rule is that the Commissioner 'may not make the connection himself.'" Martin, 2017 WL 1313837, at *3 (quoting Wilson v. Colvin, No. 13-CV-6286P, 2015 WL 1003933, at *21 (W.D.N.Y. Mar. 6, 2015)).

"In light of the ALJ's affirmative duty to develop the administrative record, an ALJ cannot reject [or ignore] a treating physician's [opinion] without first attempting to fill any clear gaps in the administrative record." Burgess v. Astrue, 537 F.3d 117, 129 (2d Cir. 2008)(quoting Rosa v. Callahan, 168 F.3d 72, 79 (2d Cir. 1999)); see Schaal v. Apfel, 134 F.3d 496, 505 (2d Cir. 1998)("Even if the clinical findings were inadequate, it was the ALJ's duty to seek additional information from [the treating physician] sua sponte.")).

> The proceedings before an ALJ are not supposed to be adversarial. Where there are deficiencies in the record, an ALJ is under an affirmative obligation to develop a claimant's medical history "even when the claimant is represented by counsel or ... by a paralegal." Perez v. Chater, 77 F.3d 41, 47 (2d Cir.1996); see also Pratts v. Chater, 94 F.3d 34, 37

> (2d Cir. 1996) ("It is the rule in our circuit that 'the ALJ, unlike a judge in a trial, must herself affirmatively develop the record' in light of 'the essentially non-adversarial nature of a benefits proceeding.' This duty ... exists even when ... the claimant is represented by counsel." (quoting Echevarria v. Secretary of Health & Human Servs., 685 F.2d 751, 755 (2d Cir. 1982))).

Richardson v. Barnhart, 443 F. Supp. 2d 411, 423 (W.D.N.Y. 2006).

Because there is no medical source opinion or functional assessment supporting the ALJ's finding that Ms. Green can perform the full range of light work, the Court concludes that the RFC determination is without substantial support in the record and a remand for further administrative proceedings is appropriate. See House v. Astrue, No. 5:11-CV-915 (GLS), 2013 WL 422058, at *4 (N.D.N.Y. Feb. 1, 2013) (citing Suide v. Astrue, 371 F. App'x 684, 689-90 (7th Cir. 2010) (holding that "the evidentiary deficit left by the ALJ's rejection" of a physician's reports, but not the weight afforded to the reports, required remand.)).

On remand, the ALJ should develop the record as necessary to obtain opinions as to plaintiff's functional limitations from treating and/or examining sources, obtain a consultative physical examination and/or a medical expert review, obtain a functional capacity evaluation, and obtain

emergency room treatment records from Erie County Medical Center and/or Kenmore Mercy Hospital for neck or low back pain [Tr. 61-62 (plaintiff testifying that she has sought emergency care approximately ten times for pain related issues), Tr. 510-11 (August 9, 2015, emergency room treatment records noting plaintiff presented with "worsening neck pain that is radiating down into her left arm." On examination noting "symptoms suggestive of a C6 C7 radiculopathy likely secondary to muscle spasm after sprain of the neck.")].

The Commissioner on remand should thoroughly explain his findings in accordance with the regulations.[3] See Martin, 2017 WL 1313837, at *4 ("There were many avenues available to the ALJ to fill the gap in the record....")(citing Covey v. Colvin, 204 F. Supp. 3d 497, 507 (W.D.N.Y. 2016)). The Commissioner on remand, "should employ whichever of these methods are appropriate to fully develop the record as to [Green's] RFC." Id. 2017 WL 1313837, at *4.

[3] Plaintiff also states that a March 13, 2013, treatment record from DENT, was reviewed by Dr. Medved and is missing from the record. [Doc. #15-1 at 26]. There is a DENT record dated March 5, 2013 and electronically signed by Dr. Lixin Zhang in the record. [Tr. 276, 456-59]. On remand, the Commissioner should obtain any additional treatment records from DENT.

As noted earlier, the Court's role in reviewing a disability determination is not to make its own assessment of the plaintiff's functional capabilities; it is to review the ALJ's decision for reversible error. Because the Court has found the ALJ erred in failing to evaluate the opinion of treating orthopedic surgeon Dr. Huckell, it need not reach the merits of plaintiff's remaining arguments. Therefore, this matter is remanded to the Commissioner for further administrative proceedings consistent with this ruling. On remand the Commissioner will address the other claims of error not discussed herein.

The Court offers no opinion on whether the ALJ should or will find plaintiff disabled on remand. Rather the Court finds remand is appropriate to permit the ALJ to evaluate Dr. Huckell's opinion and develop the record accordingly.

VI. CONCLUSION

For the reasons stated, plaintiff's Motion for Judgment on the Pleadings **[Doc. #15]** is **GRANTED**. Defendant's Motion for Judgment on the Pleadings **[Doc. #22]** is **DENIED**.

In light of the Court's findings above, it need not reach the merits of plaintiff's other arguments. Therefore, this matter is remanded to the Commissioner for further administrative proceedings consistent with this opinion. On remand, the Commissioner shall address the other claims of error

not discussed herein.

This is not a Recommended Ruling. The parties consented to proceed before a United States Magistrate Judge [doc. #11] on September 25, 2018, with appeal to the Court of Appeals. Fed. R. Civ. P. 73(b)-(c).

SO, ORDERED at Bridgeport, Connecticut this 19th day of March 2019.

/s/
HOLLY B. FITZSIMMONS
UNITED STATES MAGISTRATE JUDGE